

ORTHOPAEDIC SURGERY NEW PATIENT QUESTIONNAIRE

Patient Name:	Date of Birth:	A	ge:	_ Sex: M F Email:	
Referred by: Physician:	Self	Family	Fri	end Insurance Company (Other
Reason for visit: SHOULDER	ELBOW WRIST	HAND H	IP KN	IEE ANKLE FOOT OTHER	·
Which side? RIGHT LEFT BO	TH What is your	dominant	side: F	RIGHT LEFT AMBIDEXTRO	US
When did your condition start?	(date)/				
Is your condition due to a speci-	fic injury? YES NO) If no, w	vas the	onset: GRADUAL SUDDEN	
Is there a workers' compensation	on or no fault claim	? NO YES	3		
Please briefly describe the injur	ry or onset of the co	ndition:			
If you have had other orthoped	=	_			
Orthopedic injury:					
Orthopedic surgery:					
Please rate the severity on scale	1-10 (10 being mos	t severe) N	Now: _	At its worst:	
Descrbe the quality of the pain	(circle all that apply	y): DULL	ACHY	SHARP BURNING TINGLI	NG
Is the pain constant or intermit	tent? CONSTANT	INTERM	ITTEN	T	
Associated symptoms (circle all	that apply) PAIN	AT NIGHT	STI	FFNESS SWELLING	
INSTABILITY WEAKNES	S NECK/BACK P.	AIN RA	DIATI	NG PAIN NUMBNESS/TIN	GLING
What makes it better?		What mak	kes it w	orse?	
Have you had prior studies? X					
Have you tried any previous tre	eatments?				
TYLENOL / ADVIL / NS.	AIDS DICE	HEAT [] PHY	SICAL THERAPY BRACI	NG
☐ INJECTIONS (Date:	OTHER	·			
CURRENT MEDICATIONS (1	ist all medications,	vitamins, s	upplen	nents)	
Name Dos	se/Frequency	Nam	e	Dose/Frequenc	cy
1		5			
2					
3		7			
4		8			
KNOWN ALLERGIES (list any	allergies and reaction	on):			
Are you allergic to Iodine:	Yes No Latex:	Yes No	Metal	. iewelry. or nickel: Yes No	
PAST SURGICAL HISTORY				, j -	
Type of operation / reason		LIZITIO	1.1	Approx Date	
1	•			11	
2.					
3.					
Have you ever had a problem w	vith anesthesia?	Yes	No	Problem:	
Have you ever had complication	ns from surgery?	Yes	No	Problem:	

MEDICAL HISTORY (circle any past or current medical conditions below) Diabetes Infection Pulmonary embolus Anxietv Arrhythmia Gout Kidney disorder Reflux Rheumatoid arthritis Asthma Heart attack Low acting thyroid Bleeding problems Heart failure (CHF) Open wounds / Ulcers Seizures Blood clots (DVT-PE) Osteoarthritis Hepatitis Stomach ulcers Cancer High blood pressure Osteoporosis Stroke Coronary heart disease High cholesterol Peripheral vascular disease Other: Depression HIV / AIDS Pneumonia Are you currently on any blood thinners? NO YES If yes, which one: Have you ever had a MRSA infection? NO YES Do you have any of the following medical devices (circle any that apply)? Shunt for hydrocephalus Pain pump Neurostimulator Pacemaker or debrillator Have you been taking opioids for 6+ months? NO YES **FAMILY HISTORY** Please circle if any of your family (parents, siblings, grandparents) have a history of any of the following: Abnormal bleeding Diabetes Heart disease Rheumatoid arthritis Anesthesia complications Cancer Type: **SOCIAL HISTORY** Do you smoke tobacco? NO YES PAST # packs per day _____ # of years ____ Do you drink alcohol? NO YES How many drinks per week? ___ History of substance abuse? NO YES List any recreational activities / sports you are involved in: Current occupation? ______With whom do you live? **REVIEW OF SYSTEMS** (Have you had any of the following in the past year?) Hematologic Respiratory Constitutional Skin Fever Easy bruising / bleeding Cough Sores / ulcers Blood clots in legs Chills Difficulty breathing Hives Blood clots in lungs Wheezing Night sweats Rash Weight Change Excessive snoring Mole changes **ENT** Endocrine Cardiovascular Musculoskeletal Headaches Chest pain Cold intolerance Joint pain Joint swelling Hearing loss **Palpitations** Heat intolerance Glaucoma Leg swelling Excessive thirst Joint stiffness Poor circulation Dry eyes Muscle spasm Mouth sores Cold hands / feet Muscle weakness Neurologic Gastrointestinal Genitourinary **Psychiatric** Bladder incontinence Seizures Depression Abdominal pain Anxiety Heartburn Blood in urine Dizziness Difficulty swallowing Painful urination Memory problems Numbness Constipation Urinary retention **Paralysis** Insomnia I hereby certify the above is true and accurate to best of my knowledge. Patient Name: _____ Patient Signature _____ Date: _____ Date: _____ Reviewed by: _____